gender ratio between cases and controls was unequal, albeit non-significantly so, this could not account for the marked differences observed in IQ scores. On the one hand, the difference between the two groups was around one standard deviation, which is much more than the commonly observed difference of 0 to 1 points between genders (Hedges & Nowell, 1995). This was the case both for verbal (difference=12.5 points, P=0.01, Student's t-test) and performance IQ (difference=19 points, P=0.002, Student's t-test). On the other hand, males had a higher mean IQ (WISC or WISC-R) score, and this was observed both for cases and controls, and there were more males among the cases but more females among the controls. The mean IQ scores in the sample were 97.1 for females, 98.9 for males (difference=1.8, P=0.75, Student's t-test, cases: 85.0 females v. 90.1 males, P=0.60; controls: 104.5 females v. 107.5 males, P=0.64).

With respect to the second main issue, it has been routine practice at the Maudsley to defer IQ testing of psychotic or very depressed adolescents and those on high doses of antipsychotic medication. The performance IQ may yet not adequately reflect premorbid IQ. However, the verbal IQ was also significantly lower for cases than controls (cases: 92.6, s.d. 15.9; controls: 105.1, s.d. 13.1, P=0.01, Student's t-test). Scores that were regarded as unreliable by the assessing psychologist were not included in the study. On a few occasions more than one IQ test had been performed on the same subject in adolescence, in which case only the highest scores were entered into the database for statistical analysis.

Subjects for whom psychometric results were not available had IQ estimates imputed by clinicians contemporaneously, as this was and remains an item in the 'item sheets' which teams are expected to complete for every patient. This is usually estimated in light of school reports and grades, history given by informants and interviews with the subjects, the main purpose being to identify those with very low IQ. We only used these estimates to create a binary variable with a cut-off of 85 for logistic regression modelling. In the total sample, eight subjects (all cases) had an estimated IQ below 85. The validity of this categorisation had been confirmed by formal psychometric testing.

Lastly, 14 out of those 15 patients in the sample who had experienced a neurodevelopmental delay (11/12 cases, 3/3 controls) had their IQ tested. The mean IQ scores differed significantly between these subjects and those who had not experienced neurodevelopmental antecedents (88.6 v. 104.3, P=0.005, Student's t-test). This relationship provided strong support for our conclusion, linking IQ test scores to developmental delay. As referred to by McConville & Walker, other factors may also have contributed to the discrepancy in mean IQ between the groups. We stand by our conclusion that the differences in IQ scores between cases and controls support our main results, the significant association between neurodevelopmental antecedents and early-onset bipolar affective disorder in our sample.

Hedges, L. F. & Nowell, A. (1995) Sex differences in mental test scores, variability, and numbers of high-scoring individuals. *Science*, **269**, 41–45.

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Homicides and community care: the evidence

Sir: Like Taylor & Gunn (1999), we have been looking at statistics bearing on homicides and serious violence by mentally ill persons. We also see no support for an alleged failure of community care.

We have concentrated on the past decade. Between 1987 and 1995 the number of National Health Service (NHS) beds in England and Wales continued to fall (67 130 to 39 480), compensated in number but not in staffing levels by beds in the private sector and in staffed residential homes. As Taylor & Gunn point out, while total homicide convictions in England and Wales increased substantially after 1965, this was not paralleled by Section 2 (diminished responsibility) manslaughter convictions under the Homicide Act 1957. Indeed, we calculate they declined significantly in the decade 1987–1997 (regression slope on year: $B=-2.94$, s.e.=0.60; $t=-4.9$; $P>0.001$).

However, while homicides by people with mental illness have been steady or declined, the number of compulsory orders under the Mental Health Act 1983 (MHA) has increased dramatically (Fig. 1). Department of Health statistical bulletins (Department of Health, 1996, 1997, 1998*a*,*b*) show a 64% increase in compulsory admissions in England (1986–1996),

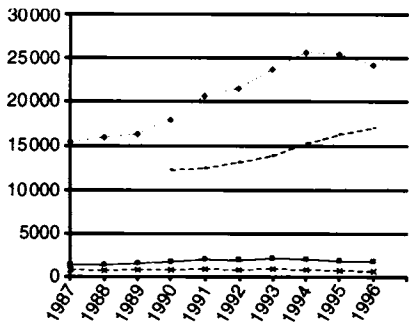

Fig. 1 Compulsory admissons to NHS facilities, special hospitals and private mental nursing homes in England: 1987–1996. Total orders (-◆-), changes from informal to compulsory order (- - -) and total court and prison orders (–■–) and Section 37 hospital orders (- ✱ -).

and a 40% increase in use of MHA sections following initial informal admission (1990–1996). However, total court and prison orders have not changed over the period 1987–1996, despite a marked increase in pre-sentence Section 48 transfers from prisons to hospitals as part of a policy aimed at providing more timely psychiatric care for remanded prisoners with mental illness. Especially noteworthy is the fact that Section 37 hospital orders (with or without restrictions) made after conviction have remained unchanged.

Perhaps the emphasis on the tenets of the Care Programme Approach (CPA) and implementing assertive community treatment have resulted in both an increase in MHA sections and a reduced risk of homicides. Of special concern is the possibility that widespread fears that one of their patients may kill have lowered mental health teams' thresholds for using compulsion, possibly quite unnecessarily, and at substantial cost to patients' liberties.

Despite the pronouncements of homicide inquiries, sadly biased by only examining worst outcomes, community psychiatric services have probably implemented the major elements of the CPA and are more assertive than ever before in ensuring that patients do not fall through the net of services. A national survey conducted by us for the Department of Health has shown that about 1% of the population is on a CPA register, and about 1% of these are on a Supervision Register (Bindman *et al*, 1998). Ironically, it is plausible that by being more accessible and reaching out more effectively to those suffering from a mental disorder who would have been

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undetected or lost to services in the past, more people who commit a homicide have been in contact at some time with mental health services. This might, therefore, have led to the false perception that more people with a mental disorder are killing than before, when in reality the absolute numbers are steady despite a rise in total homicides.

Bindman, I., Beck, A., Glover, G., *et al* (1998) *Evaluating Mental Health Policy in England: The Care Programme Approach and Supervision Registers*. London: Department of Health.

Department of Health (1996) *Inpatients Formally Detained in Hospitals under the Mental Health Act 1983 and Other Legislation. England, Regional Office Areas, Trusts and Directly Managed Units: 1994–95*. London: Government Statistical Service.

— **(1997)** *In-Patients Formally Detained in Hospitals under the Mental Health Act 1983 and Other Legislation, England: 1990–91 to 1995–96* (Statistical Bulletin 1997/4). London: HMSO.

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— **(1998b)** *In-Patients Formally Detained in Hospitals under the Mental Health Act 1983 and Other Legislation. NHS Trusts, High Security Hospitals and Private Facilities: 1996–97*. London: Government Statistical Service.

Taylor, P. J. & Gunn, J. (1999) Homicides by people with mental illness: myth and reality. *British Journal of Psychiatry*, **174**, 9–14.

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Orphenadrine – presence in patients not using antipsychotic drugs

Sir: The higher than expected use of orphenadrine and its presence in patients not using antipsychotic drugs (Slordal & Gjerden, 1999) are readily explained by its value as a drug of abuse. It is a stimulant which has been saleable on the street in the USA and the UK for 25 years. It is less used now in the UK because procyclidine is more widely prescribed as an anti-muscarinic drug and because drug dealers can provide reliable supplies of other, more powerful stimulants.

Slordal, L. & Gjerden, P. (1999) Orphenadrine. *British Journal of Psychiatry*, **174**, 275–276.

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Importance of case reports in psychiatry

Sir: The Editor of the *Journal* is to be congratulated on the publication of a paper on this (some of us believe) very important issue in psychiatry (Farmer, 1999). Farmer might have mentioned that most general psychiatric journals have become non-receptive to case reports. The *American Journal of Psychiatry* announced in 1976 that it would no longer publish case reports as full articles (Pincus *et al*, 1993). It is all done, of course, in the name of scientific method because there may be problems in extrapolating the findings from a single case report. Are the editors of our esteemed professional journals underestimating the power of human (clinical) observations?

Farmer seems to agree partially and even go on to say that "much scientific research would not have progressed without the insights made on single cases" but concludes that the usefulness of the case report is limited and that it should only be considered if it meets scientific standards in a Popperian sense (it either generates a hypothesis or refutes one). She might have added 'testability' of the hypothesis too and further, that some hypotheses are hard to refute. She does not mention how absolute this criterion is. Could a case report not add to the existing body of knowledge, for example? Many clinicians who read the *Journal* are not always looking for paradigm shifts but for nuggets of interesting clinical permutations that are best generated by curious clinicians (who observe many patients but may not know the method) and clinical researchers who far outnumber the clinical academicians (who research using the same vitiated presumptions and use increasingly fancy technical tools but do not see many patients). Published descriptive observations in the form of case reports or case series may indeed inspire an academician – versatile in the scientific method, or even regarding method as more important than substance – to do larger studies.

The new era of diagnostic certainty assures us reliability in diagnosing mental disorders but such an approach cannot ensure validity. No one will assert that the modern diagnostic system in psychiatry is complete by any means. Psychiatry has known many false dawns and has much to gain from clinical experience (Shiwach, 1997). It remains a mystery why the leaders of our profession, whose classification system is based on descriptive psychopathology, choose to ignore descriptions of pathology in the form of case reports.

Farmer, A. (1999) The demise of the published case report – is resuscitation necessary? *British Journal of Psychiatry*, **174**, 93–94.

Pincus, H. A., Henderson, B., Blackwood O., *et al* (1993) Trends in research in two general psychiatric journals in 1969–1990: research on research. *American Journal of Psychiatry*, **150**, 135–142.

Shiwach, R. S. (1997) Literature and history in medicine. *Lancet*, **349**, 1393–1394.

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One hundred years ago

"The growth of insanity in Scotland"

An article under this heading, "contributed" to *The Scotsman* of 8 December 1897, draws attention to the existence of "crazy" areas in Scotland. Thus, while the ratio of the insane in Scotland generally for the 1895 quinquenniad was 27.1 per 10,000, this is described as rising to 90 per 10,000 in the parishes in Argyllshire, but the writer does not draw attention to the fact that in the twenty-five remaining parishes the ratio must, on his own showing, fall below the average.

Craignish and Kilmelfort, with populations of 389 and 407, are stated to have a ratio of 170 per 10,000. This sounds very

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